

FILED AUG 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28689**
6962
Registrar's No. _____

318 PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | | | | | |
|---|-------------------------------|--|--|--|---|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.) | | c. LENGTH OF STAY (If in this place) 10 yrs. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129 | | d. STREET ADDRESS (If rural, give location) 5381 Delmar | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Home of Missouri | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Pearl b. (Middle) Sneed c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) 8-11-1950 | | | | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH January 19, 1868 | 9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 Wk. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) McKinney, Texas | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME William Bagley | | 13b. MOTHER'S MAIDEN NAME Amanda James | | 14. NAME OF HUSBAND OR WIFE William A. Sneed | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Masonic Home of Mo., 5351 Delmar Blvd. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis | | | | 3 mo | |
| | | ANTECEDENT CAUSES Chronic Interstitial Nephritis DUE TO (b) 2 yrs | | | | | |
| | | *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | | |
| | | DUE TO (c) _____ | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS. History of Goiter. | | | | 30 yrs | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 5-2-40 | | 21f. HOW DID INJURY OCCUR? 592X | | | |
| 22. I hereby certify that I attended the deceased from 8/11/50 , to 8/11 , 19 50 , that I last saw the deceased alive on 8/11 , 19 50 , and that death occurred at 10:40 p.m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Harold E. Walters, M.D. (Degree or title) | | | | 23b. ADDRESS 508 N Grand | | 23c. DATE SIGNED 8/12/50 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removed | | 24b. DATE 8-12-50 | | 24c. NAME OF CEMETERY OR CREMATORY Excelsior Spgs Mo | | 24d. LOCATION (City, town, or county) (State) _____ | |
| DATE RECD BY LOCAL REG. AUG 16 1950 | | REGISTRAR'S SIGNATURE J B Fasano | | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc. | | | |

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Van M Sizemore*

Licensed Embalmer No. *4343*

P. O. Address *St Louis 10 - Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.